[COMMITTEE PRINT]

MEDICARE AND MEDICAID'S 25TH ANNIVERSARY—MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED

A REPORT

PRESENTED BY

THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 30, 1990

Comm. Pub. No. 101-762

Printed for the use of the Select Committee on Aging

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U.S. GOVERNMENT PRINTING OFFICE

33-025 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
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PREFACE

In 1985, we labeled the 20th anniversary as a "bittersweet" occasion because the history of Medicare and Medicaid is replete with many accomplishments, many problems and many gaps. On the occasion of the 25th anniversary of these two key health protection programs, the label still applies and the feeling is the same. While there has been some progress, much of the promise and hope enshrining these two programs remains unfulfilled.

As is shown in this report, there is much of which to be proud with respect to Medicare and Medicaid. Each year since Medicare and Medicaid began, millions of Americans who are poor, are elderly or have major disabilities have received care funded by these two programs. Medicare has relieved a large portion of the financial burden of acute care costs for its beneficiaries. Medicaid has taken away the financial burden of acute and long term nursing home costs for those who became Medicaid beneficiaries. This is no small accomplishment during a time when health care costs have skyrocketed and America has seen its elderly population grow significantly and its poor population remain substantial. Much to their credit, Americans of all ages have continued to support these programs not only with their words but with their tax and premium dollars.

But there is another side to this success story. For all their accomplishments, the Medicare and Medicaid programs have problems. Rising health care costs have put enormous pressure on these programs, the American taxpayer, and the beneficiaries. Even with more than a decade dedicated to cost containment, effective cost containment is still out of our reach. As just one example, our own study has shown that today's elderly are spending nearly one-fifth of their income on health care, one and one-half times higher than the level in 1977.

Over the past 25 years, quality assurance efforts have made major strides forward but have still to fully address health and long term care quality in many settings, including ambulatory care and home care. Further, much of today's quality assurance is tied to Medicare and, to a lesser extent, Medicaid leaving the privately insured and the uninsured without adequate protection. Also, quality assurance has acquired a new rationale in a period of cost containment. Much more than in the past, quality assurance can become a means for measuring the impact of cost containment policies and documenting when and where cost containment may do or be doing damage.

For all the people who have been protected by these programs, there are many more who remain unprotected. Today, 31-37 million Americans are uninsured for health care at any point in time. Nearly twice that number experience being uninsured in a two year period. Many millions more remain at risk as their insurance is woefully inadequate to meet the challenges and the costs of modern day health care.

Since 1965, long term care protection has emerged as a weak spot in our system. Today, over 200 million Americans are uninsured against long term care costs and the only large scale program protecting younger and older Americans is Medicaid. Unfortunately, a person's price of admission to Medicaid and its long term care protection is either being poor or spending down into poverty.

Turning to the future, it is again likely to be a time of great turmoil for health and long term care in America. Unless we enact large scale reform, health and long term care costs are likely to continue to outstrip our ability to pay for them. Without large scale reform, the number of Americans without health insurance will remain over 30 million and the number of Americans without long term care insurance protection will remain over 200 million. None of these "status quo" situations is tolerable.

Today, we are fortunate to have many reform proposals on the table from a wide spectrum of organizations, coalitions and members of Congress. Many of the proposals would shore up one or more of the weak spots and gaps in Medicare, Medicaid or private insurance protection. Some proposals focus more on private sector solutions while other focus more on public sector strategies.

More and more proposals are being designed to bring about comprehensive health and long term care reform. Some, such as my own USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Over the past 25 years, much has been promised and much has been accomplished with respect to Medicare and Medicaid. However, the final chapter on health and long term care reform in America is far from having been written as much is left unfinished. The task now falls to the Administration and Congress, the public custodians of Medicare and Medicaid, to complete the agenda and to ensure that no American lacks financial access to needed health and long term care care and that no American need fear financial and emotional ruin from costly and disabling illnesses.

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

ACKNOWLEDGEMENT

The Chairman would like to express his deep appreciation to Dr. Tony Hausner, a Health Care Financing Administration employee on detail to the Select Committee on Aging, for his valuable assistance in helping draft this report commemorating the 25th anniversary of the Medicare and Medicaid programs.

EXECUTIVE SUMMARY

Twenty-five years ago on July 30, 1965, President Johnson signed into law the Medicare and Medicaid programs as Titles XVIII and XIX respectively of the Social Security Act. As enacted, the Medicare program was designed as a national, federally administered program with uniform eligibility and benefits tied to the Social Security program. Part A, the hospital insurance program, provides protection for mostly inpatient acute care; while part B, the supplementary medical insurance fund, covers doctor visits and other ambulatory services.

The Medicaid program is a Federal grant program which is administered by the States and is targeted toward lower income individuals and families. It covers a broad range of hospital, nursing facility and other medical services.

When these programs were enacted, many persons expected that Medicare and Medicaid would ensure full coverage of all health care services for the elderly, disabled, and the poor. While these programs have gone through many changes in their 25 year history, and much has been accomplished during this time period, this report will indicate that there remain many gaps and weaknesses in the programs.

Accomplishments. The Medicare and Medicaid programs have made many important contributions to the health care needs of the elderly, disabled, and the poor. The following statistics give some indication of this contribution. In 1989, society contributed over $120 billion to parts A and B of the Medicare program, and $54 billion to the Medicaid program. These programs have primarily been funded by the taxpayer though Social Security and general income taxes, and by the elderly through these taxes and through premiums.

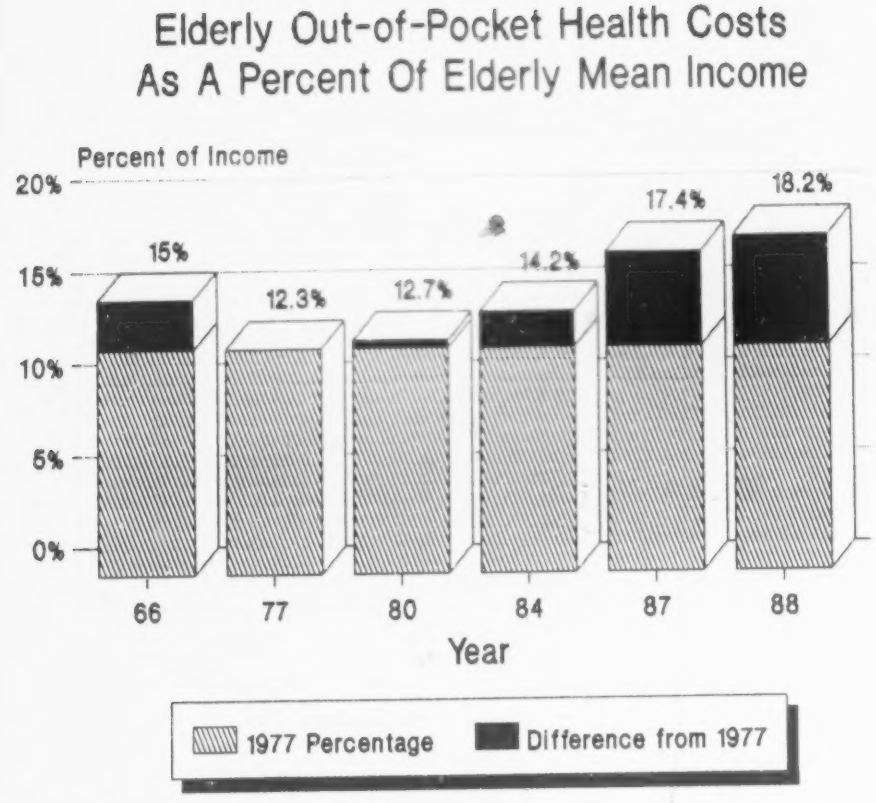
Over the years, these programs have served many beneficiaries, and, therefore, have provided them access to health care and protected them from much of the burden of considerable health care costs. In 1989, Medicare served 32.5 million beneficiaries and Medicaid served 23.5 million beneficiaries. An examination of a few key services gives an even better perspective on these programs' contributions. In 1987, Medicare provided nursing home care to 300,000 persons, and physician and other medical services to 23 million persons. For Medicaid in 1988, the number of beneficiaries who received skilled and intermediate nursing home care was 1.59 million and the number who received physician services was 15.26 million.

Gaps and Weaknesses in Medicare and Medicaid. Despite the many accomplishments of these programs, there still remain many gaps and weaknesses that need to be resolved.

Health care costs have been rising more rapidly than the cost of living for at least the past two decades. This has created problems for the entire health care field, for Medicare and Medicaid, and for the elderly, the disabled, and the poor. For instance, between 1983 and 1989 medical care prices rose at twice the rate of inflation. For the elderly and others with lower, relatively fixed incomes, this has particular consequences. The elderly's out-of-pocket costs increased from 12.3 per cent of their income in 1977 to 18.2 per cent in 1988 (see Figure E.1).

Over the past 25 years, quality assurance efforts have made major strides forward, but have still to fully address health and long term care quality in many settings, including ambulatory and home care. Further, much of it is tied primarily to Medicare, and, to a lesser extent, Medicaid; whereas the privately insured and uninsured have little protection.

FIGURE E.1 —

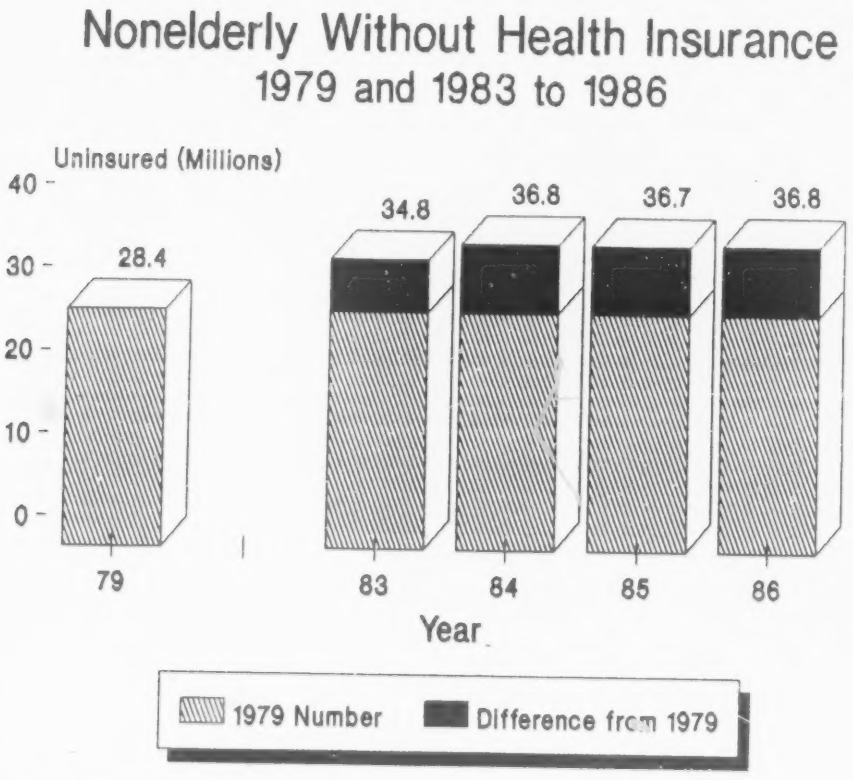


Source: House Committee on Aging, 1990

Medicare and Medicaid also have many gaps as to services and persons covered. The Catastrophic Care Act of 1988, repealed in 1989, identifies one set of services that are not covered. There are long term care services, dental services, and other services that are not covered by these programs. Another gap is that Medicaid only covers 42 per cent of persons below the poverty line. Medicaid also suffers from low participation by many hospitals, physicians, and other providers.

A further gap of great importance is the number of persons who are un- and underinsured. Studies show that the number of persons who have no health insurance has grown from 28 to 37 million persons between 1979 and 1986 (see Figure E.2). When facing a catastrophic acute or long term illness, over 200 million Americans are underinsured.

FIGURE E.2 —



Source: Current Population Survey, Census Bureau

Future of Federal Role in Health and Long Term Care. Fortunately, there are many reform proposals on the table from a wide spectrum of organizations, coalitions, and members of Congress. One set of proposals represent expansions and improvements to the Medicare and Medicaid programs.

A second set of proposals are designed to bring about comprehensive health and long term care reform. Some, such as Congressman Roybal's USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Looking to the future, the nation has two responsibilities. The first responsibility is one of stewardship over Medicare and Medicaid as they are today. The second responsibility is to those who have yet to benefit from this nation's greatest step forward toward protecting the health of its citizens.

When millions live at risk and in fear of a long term disabling illness wiping out the financial and emotional resources of their families, a nation cannot be satisfied with Medicaid as the nation's primary long term care policy. When millions are forced to seek charity for whatever health care they need, a nation can feel no pride in having the best medical care in the world.

In a world which has increasing doubts over the United States' ability to step forward and show leadership on the great issues of the day, health and long term care protection is one case where this nation not only fails to lead but fails to keep up. Twenty-five years would seem to have been enough time for this nation to take its rightful place of leadership; thirty years would seem to be too long.

NOTE: For further information on the Committee's consideration of the Medicare and Medicaid programs and their future, contact Gary Christopherson, Yvonne Santa Anna, Dr. Tony Hausner or Carolyn Griffith at the House Select Committee on Aging, Room 712, House Annex 1, Washington, D.C. 20515. Phone: 202-226-3375.

INTRODUCTION

On the 25th anniversary of Medicare and Medicaid, the two largest government efforts to ensure protection for its citizens health, it is important to reflect upon the history of these critical programs and to dedicate the nation to future efforts to fulfill their great promise.

In the course of this report by Chairman Roybal of the Select Committee on Aging, an effort will be made to examine how the programs came about and what was hoped they would accomplish. Based upon implied promises and the actual legislation enacted, this report reviews Medicare and Medicaid as they were when enacted into law on July 30, 1965 and the considerable changes that have occurred since their enactment. Over the past 25 years, laws have been enacted to expand eligibility and coverage of services, to improve methods of paying for services, to strengthen efforts to assure the quality of services provided, and to constrain the rate of growth in program expenditures. Over the last 15 years, cost containment has emerged as a major priority and, in some peoples' view, the major priority. Other people believe that the major priority is the effort to expand eligibility to cover the uninsured and to expand coverage for long term care.

However, to look only at the legislation would be to lose sight of the great value of what society contributes and what the elderly, poor and disabled receive. In that regard, the report will measure society's contribution not only by their 25 years of unwavering political support but also their financial contributions through income taxes, payroll taxes, and premiums. The value of Medicare and Medicaid can be measured in many ways. One way is the benefits received, e.g., the people receiving care in hospitals, nursing homes and from physicians. Another, less tangible, way is the increased financial and emotional security of Medicare and Medicaid beneficiaries.

Within the story of people protected and benefits received, is the other story. This is the story of people left unprotected and of health and long term care left uncovered. In one case, it is the nation's inability to constrain health and long term care costs to keep them affordable for everyone, whether they be government, employer or individual. Another case is the 30 plus million people without health insurance. Another is the 200 plus million people without long term care protection, except for the prospect of Medicaid. No matter how people view the limitations of Medicare and Medicaid, virtually everyone agrees that the elderly, poor and disabled are far better off with them. Most agree that much work lies ahead for the nation.

Finally, a proper consideration of the 25th anniversary of Medicare and Medicaid must include a view to the future. As will be shown in this report, much work remains before the Medicare and Medicaid's gaps and weaknesses are repaired and before their full promise is achieved. Whether their full promise is best achieved through the repair and refinement of Medicare and Medicaid or through a comprehensive reform building upon the experience of Medicare and Medicaid is what will dominate the health policy debate of the next decade.

THE PROMISE.

History Of Efforts Prior To Medicare and Medicaid. The foundations of Medicare and Medicaid are first found in the passage of the Social Security Act of 1935 and then in a series of medical programs in the 1950's which consisted of medical payments for certain needy individuals, all of which were linked to cash welfare programs, as is today's Medicaid program. In 1950, Congress authorized a strategy of vendor payments for medical assistance to the aged, blind, and disabled. Then in 1956, they added disability insurance benefits. In 1960, the Kerr-Mill amendments were approved which covered the needy aged. Extensive criticism was directed at this legislation because it did not cover the majority of the aged.

At that time, private health insurance covered some but not all of the elderly. A 1963 survey showed that only 56 percent of the elderly had hospital insurance (see Health Care Financing Administration (HCFA), 1985). Yet the aged were identified as being at considerable risk since they had the highest rates of illness and, at that time, the lowest incomes. It was with this as background that Medicare and Medicaid were enacted.

Enactment Of Medicare and Medicaid. Medicare was enacted into law on July 30, 1965 as Title XVIII of the Social Security Act. It was designed as a national, federally administered program with uniform eligibility and benefits and was tied to the Social Security program. The hospital insurance program, part A, provides protection for acute care needs with benefits structured around episodes of illness. It covers all expenses for the first 60 days minus a deductible; for days 61-90, a coinsurance amount is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount is deducted for each reserve day.

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Part A will also pay for up to 100 days in a skilled nursing facility; after the first 20 days, a daily coinsurance amount is deducted. Subject to need, it also pays for home health visits for homebound individuals.

Medicare Part B, the supplementary medical insurance fund, pays 80 percent of approved charges and covered services in excess of an annual deductible. Covered services include doctor visits, such as surgery, consultation, home, office, and institutional visits; other medical and health services, such as laboratory and diagnostic tests, radiation, therapy, outpatient services, artificial devices, physical and speech therapy, and ambulance services; and home health services not covered by part A.

Medicaid was also enacted on July 30, 1965 as Title XIX of the Social Security Act. It is a Federal grant program which is administered and partly funded by the States and is limited to low income individuals and families. It covers those persons eligible for existing welfare programs. In addition, States may provide for the medically needy who are individuals not eligible for cash assistance because of income limits but whose medical bills exceed their income to the point that they meet the states medically needy standards.

Title XIX requires that every State offer hospital inpatient and outpatient care, laboratory and X-ray services, skilled nursing facility services, physician services, family planning, and early and periodic screening, diagnosis, and treatment for persons under 21 years of age. In addition, States may provide a number of other services at their option, including prescription drugs, eyeglasses, intermediate care facility services, inpatient psychiatric care, physical therapy, and dental care.

Modification Of Medicare And Medicaid Since 1965. There have been extensive changes to the Medicare and Medicaid programs since their enactment. This section will highlight some of the key changes first to Medicare and then to Medicaid.

The 1972 Social Security Amendments added the following provisions to the Medicare program: coverage to disabled persons receiving cash benefits for 24 months under the social security program and persons suffering from end-stage renal disease; and Professional Standards Review Organizations in which medical and health care professionals reviewed the medical care delivered by Medicare providers.

The 1982 Amendments added the following provisions: hospice coverage for the terminally ill; encouragement of the Medicare program to contract with Health Maintenance Organizations and other Competitive Medical Plans; and the replacement of Professional Standards Review Organizations by Peer Review Organizations. The latter program involved the replacement of a grant program by a contract program with more specific objectives. The 1983 Amendments established the Hospital Prospective Payment System in which hospitals are paid a set rate for each Diagnosis Related Group. This payment system replaced the previous method of reimbursing hospitals for all reasonable costs and is designed to promote greater efficiency in the delivery of hospital services.

In 1988, the Medicare Catastrophic Care Act was enacted but most of its provisions were subsequently repealed in 1989. The Act was designed to remove payments for coinsurance and limitations on the number of days of hospital care; limit to only one inpatient deductible per year; expand skilled nursing facility, home health, and hospice care benefits; and place limits on out of pocket expenses for part B services; and cover outpatient prescription drugs. The bill also contained several Medicaid provisions to be discussed below. The Medicare provisions were to be financed by an increase in the Part B premium and a new supplemental income-related premium (also referred to as a surtax) on all part A enrollees with tax liability (estimated to affect about 41 percent of the elderly in 1989). Many elderly complained about the supplemental premium and the limited advantages of the new benefits. The Medicare Catastrophic Care Act was repealed in 1989, except for the Medicaid provisions noted below.

In 1989, the President signed a budget reconciliation bill that included reforms in physician payment. The new payment system uses a relative value scale that takes into account the time, intensity, and skill of the services rendered rather than physician historical charges. It also includes a geographic adjustment factor and a volume performance standard.

In addition to these changes, the Administration and Congress have modified the Medicare program through a variety of other budget controls. These controls have taken the form of reductions or freezes in provider payments and increases in beneficiary premiums and deductibles. Between 1981 and 1987, the General Accounting Office (GAO) and HCFA estimated that these budget changes resulted in cuts of about $40 billion. Some believe that the cuts may have been even larger.

Medicaid has also gone through many changes over the years. In 1981, legislation permitted the States to exercise two options: the freedom of choice option allows the States to restrict individuals to certain providers; and home and community based waiver option allows the States to substitute such services for institutional services. Starting in 1984, legislation has been modified several times to gradually expand the population groups that States are either required or permitted to cover. The connection to cash assistance is still the primary, but no longer the only way to establish eligibility. When the latest provisions are fully implemented, States will be required to cover all pregnant women and infants below the poverty line and all children under 7 years of age meeting State eligibility standards. States also have the option to cover pregnant women and infants up to 185 percent of the poverty line. Further, as discussed below, States will be required to pay Medicare cost-sharing charges for the elderly and disabled Medicare beneficiaries with incomes below the poverty line.

Further changes in Medicaid included the 1987 Nursing Home Reform provisions that established a more uniform and stringent set of quality assurance standards for nursing homes. Finally, the Medicaid provisions retained in the Medicare Catastrophic Care Act include: coverage of Medicare premiums, deductibles, and coinsurance for individuals below the poverty line; and protection of portions of the income and assets for the spouse of an institutionalized individual.

While their have been a number of program expansions to Medicaid, there have also been a series of budget cuts to this program. In particular, budget bills in 1981 and 1982 reduced the program by over $4 billion from what many people believed was already an inadequate program of protection. While there have been modest improvements in the program since then, as of 1987, the Congressional Budget Office (CBO) estimated that the expansions restored less than 10 percent of these earlier cuts.

The Promise. Many people expected that the enactment of Medicare and Medicaid would ultimately protect the elderly and poor persons from burdensome health care costs. When President Johnson signed these bills, he stated:

> "No longer will older Americans be denied the healing miracles of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."

Medicaid also had far-reaching goals. The poor were promised that they would soon have access to mainstream medical care and that health care was a basic right.

However, the original intent of these programs was primarily to address the acute care needs of the elderly and the poor. Chronic long term care was not included. One reason that long term care was not included was that it was not as great a factor as it is today. To avoid opposition by the advocates of States rights, Congress further compromised by conceding much of the control and administration of Medicaid to the States. These compromises, as well as many other gaps and weaknesses, mean that this nation is still a long way from meeting the original dreams of Medicare and Medicaid.

ACCOMPLISHMENTS.

The Medicare and Medicaid programs have made many important contributions to the health care needs of the elderly and the poor. The following information give some dimensions to this contribution. Unfortunately, there is little information that indicates the direct effects that the provision of these services has had on the health status of the effected populations. It can only be assumed that these populations have received care that they would not have received otherwise; and, therefore, this has led to improvements in their health status.

Society's Contribution. Over the past 25 years, society has made an unwavering and significant contribution to protecting the health of the elderly, disabled and poor. As one illustration of that contribution, Table 1 indicates the total income from various components of society for the Medicare hospital insurance fund. The sources of income include payroll taxes, transfers from railroad retirement accounts, reimbursement for uninsured persons, premiums from voluntary enrollees, payments for military wage credits, and interest on investments and other income. In 1989, the fund received $76 billion. Most of the funds come from the social security payroll tax which applies to all persons who work whether or not they are over or under age 65. Thus, all components of society contribute to this fund.

A similar picture is shown in Table 2 which provides data for Medicare Part B and its supplementary medical insurance trust fund. Income is derived from beneficiary premiums, government contributions, interest, and other income. In 1989, the fund received $44 billion. Most of these funds come from government contributions, primarily income taxes. However, a significant portion, about one-quarter, does come from the premiums paid by beneficiaries.

TABLE 1 — INCOME SOURCES FOR THE HOSPITAL INSURANCE TRUST FUND, CALENDAR YEARS 1966-92.

Income (In Millions)

Calendar Year	Payroll Taxes	Interest & Other Income	Misc. Income *	Total Income
1966	$ 1,858	$ 32	$ 53	$ 1,943
1967	3,152	51	356	3,559
1968	4,116	74	1,097	5,287
1969	4,473	113	693	5,279
1970	4,481	158	1,340	5,979
1971	4,921	193	618	5,732
1972	5,731	180	492	6,403
1973	9,944	278	599	10,821
1974	10,844	523	657	12,024
1975	11,502	664	814	12,980
1976	12,727	746	293	13,766
1977	14,114	784	958	15,856
1978	17,324	834	1,055	19,213
1979	20,768	975	1,082	22,825
1980	23,848	1,149	1,100	26,097
1981	32,959	1,603	1,163	35,725
1982	34,586	2,022	1,390	37,998
1983	37,259	2,593	4,718	44,570
1984	42,288	3,046	1,386	46,720
1985	47,576	3,362	459	51,397
1986	54,583	3,619	1,065	59,267
1987	58,648	4,469	947	64,064
1988	62,449	5,830	960	69,239
1989	68,369	7,317	1,035	76,721
Alternative II-B Projection				
1990	71,429	8,520	577	80,526
1991	76,252	9,812	1,123	87,187
1992	81,041	11,034	893	92,968

* Miscellaneous income includes transfers from railroad retirement, reimbursement for uninsured persons, premiums from enrollees, and military wage credits.

SOURCE: Health Care Financing Administration, 1990.

TABLE 2 — INCOME SOURCES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1966-92.

Income (In Millions)

Calendar Year	Premiums From Enrollees	Government Contributions	Interest & Other Income	Total Income
1966	$ 322	$ 0	$ 2	$ 324
1967	640	933	24	1,597
1968	832	858	21	1,711
1969	914	907	18	1,839
1970	1,096	1,093	12	2,201
1971	1,302	1,313	24	2,639
1972	1,382	1,389	37	2,808
1973	1,550	1,705	57	3,312
1974	1,804	2,225	95	4,124
1975	1,918	2,648	107	4,673
1976	2,060	3,810	107	5,977
1977	2,247	5,386	172	7,805
1978	2,470	6,287	299	9,056
1979	2,719	6,645	404	9,768
1980	3,011	7,455	408	10,874
1981	3,722	11,291	361	15,374
1982	3,697	12,284	599	16,580
1983	4,236	14,861	727	19,824
1984	5,167	17,054	959	23,180
1985	5,613	18,250	1,243	25,106
1986	5,722	17,802	1,141	24,665
1987	7,409	23,560	875	31,844
1988	8,761	26,203	861	35,825
1989	12,263	30,852	1,219	44,334
Alternative B Projection				
1990	11,125	32,455	1,285	44,865
1991	11,781	36,492	1,216	49,489
1992	12,445	42,705	1,076	56,226

SOURCE: Health Care Financing Administration, 1990.

Another measure of societal contribution is the amount of expenditures for Medicare beneficiaries. Table 3 indicates the growth in Medicare expenditures between 1967 and 1989 with projections through 1995. In constant 1990 dollars, expenditures will have increased from $1,104 per enrollee in 1969 to $4,228 in 1995, a four-fold increase. For that period, the growth rate was fairly steady between 1975 and 1985 at around 7 percent and then decreased to 3.1 percent for 1985-1991 due to a decrease in hospital expenditures. Based on current law, the rate is projected at 6.2 percent for the 1991-1995 period.

Significant growth has also occurred for the Medicaid program. Table 4 shows that real spending per beneficiary has increased 133 per cent between 1975 and 1989, an annual growth rate of 1.9 per cent. More recently, the spending growth rate has slowed down. Between 1975 and 1980, it increased at an annual rate of 4.2 per cent. Between 1980 and 1989, it increased at a much slower annual rate of 0.9 per cent. In 1989, Medicaid spent $54 billion in combined Federal and State funds.

These data indicate that the Medicare and Medicaid programs have expended an extensive sum of funds to pay for the health care for the elderly, disabled, and the poor over the past 25 years. They also indicate that, for the most part, these programs have been strongly supported and paid for by the taxpayer, through Social Security taxes and general income taxes. The elderly have helped to pay for their coverage through these same taxes during their working and retirement years and by premiums during their retirement years.

Beneficiaries Protected. Over these last 25 years, many millions of beneficiaries have been served by these two programs, and, therefore, have been provided access to health care and protected from a substantial portion of burden of considerable health care costs. Figure 1 and Table 5 shows that the number of aged and disabled Medicare enrollees will continue to grow, rising from 23 million in 1975 to an estimated 36 million for 1995.

TABLE 3 — REAL MEDICARE SPENDING PER ENROLLEE, 1967-95.

(In Constant 1990 Dollars)

Fiscal Year	Medicare Spending
1967	$ 648
1968	960
1969	1,104
1970	1,114
1971	1,143
1972	1,194
1973	1,100
1974	1,182
1975	1,355
1976	1,481
1977	1,637
1978	1,744
1979	1,811
1980	1,954
1981	2,117
1982	2,300
1983	2,449
1984	2,554
1985	2,775
1986	2,817
1987	2,886
1988	2,960
1989	3,079
Congressional Budget Office Projection	
1990	3,230
1991	3,328
1992	3,576
1993	3,794
1994	4,012
1995	4,228

SOURCE: Health Care Financing Administration and Congressional Budget Office, 1990.

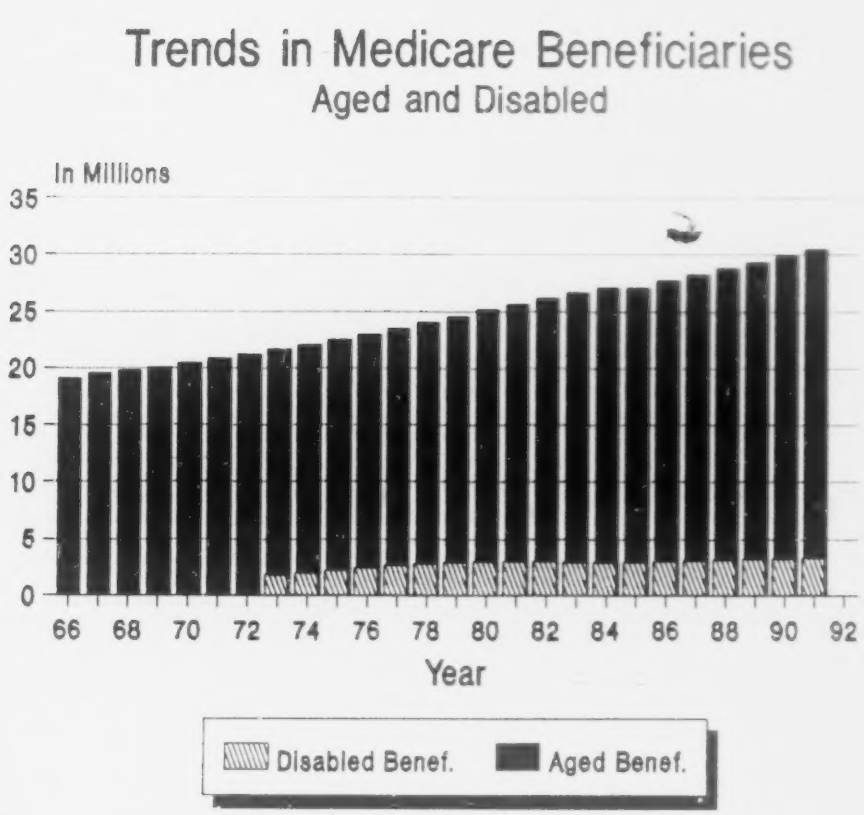
TABLE 4 -- REAL MEDICAID SPENDING PER BENEFICIARY 1975-89.

(In Constant 1982-84 Dollars)

Fiscal Year	Medicaid Spending
1975	1,171
1976	1,188
1977	1,248
1978	1,325
1979	1,409
1980	1,441
1981	1,493
1982	1,471
1983	1,494
1984	1,469
1985	1,515
1986	1,493
1987	1,498
1988	1,534
1989	1,553

SOURCE: Health Care Financing Administration, 1990.

FIGURE 1 — MEDICARE BENEFICIARIES, 1966-1995



Source: Health Care Financing Adm., 1990

TABLE 5. — MEDICARE AND MEDICAID BENEFICIARIES.

Beneficiaries (In Thousands)

Fiscal Year	Medicare Aged Benef.	Medicare Disabled Benef.	Medicaid Benef.
1966	19,082		11,500
1967	19,494		12,060
1968	19,770		14,507
1969	20,014		17,965
1970	20,361		17,741
1971	20,742		18,466
1972	21,115		21,114
1973	21,571	1,731	19,622
1974	21,996	1,928	21,462
1975	22,472	2,168	22,006
1976	22,920	2,392	22,815
1977	23,475	2,619	22,832
1978	23,984	2,793	21,965
1979	24,548	2,911	21,520
1980	25,104	2,963	21,605
1981	25,591	2,999	21,980
1982	26,115	2,954	21,603
1983	26,670	2,918	21,554
1984	27,112	2,884	21,607
1985	27,123	2,944	21,814
1986	27,728	2,986	22,515
1987	28,239	3,042	23,109
1988	28,779	3,115	22,907
1989	29,358	3,200	23,511
1990*	29,951	3,251	24,600
1991*	30,480	3,297	25,600
1995*	32,277	3,597	

* Estimate

SOURCE: Health Care Financing Administration, 1990.

As seen in Figure 2 and Table 5, there were substantial increases in the number of Medicaid beneficiaries between 1968 and 1974, the early years of the program. Since then the numbers have remained fairly steady between 21.5 and 23.5 million. The Census Bureau's Current Population Survey indicates that between 1980 and 1988 the number of Medicaid beneficiaries who were below the poverty line was also fairly constant at 12 to 13 million.

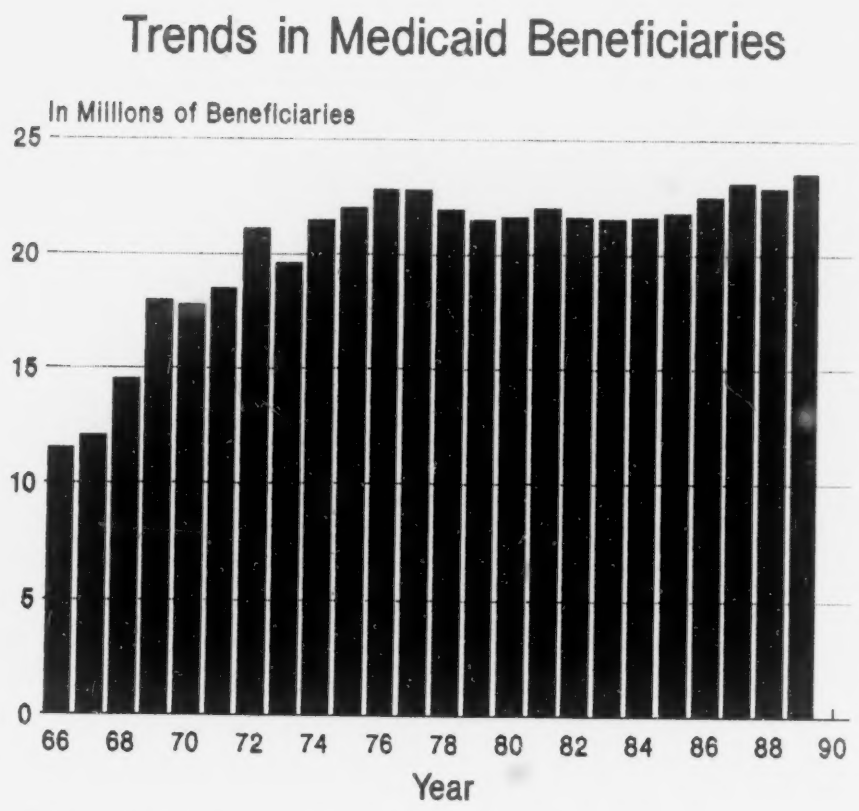
Care Provided. An examination of persons served and expenditures for different types of services provides a further perspective on the contributions that Medicare and Medicaid have made in providing health care to the elderly, disabled, and the poor. This examination will focus on physician and nursing home services, since they are good barometers of the influences of these programs.

With respect to nursing home services, Table 6 shows that the number of elderly who have received nursing home services under Medicare has stayed relatively constant at around 300,000 between 1967 and 1987. For physician and other medical services, the pattern is much different since the number served has increased from 6 to 21 million persons during this time period.

Looking instead at the proportion of Medicare dollars (expected to be $113 billion in 1991) going for different services, approximately 54 percent will be spent on hospital inpatient services and 29 percent on physician services. These figures contrast sharply with the 1975 proportions of 70 percent and 22 percent for these services respectively (see Figure 3). Thus, there has been some shift from hospital to ambulatory care over the past 15 years.

Moving to Medicaid, Table 7 shows that the number of Medicaid beneficiaries using nursing homes (skilled and intermediate) has increased from 1.14 to 1.59 million between 1973 and 1988. During the same period, the number using physician services has increased from 12.28 to 15.26 million.

FIGURE 2 — MEDICAID BENEFICIARIES, 1966-89



Source: Health Care Financing Adm., 1990

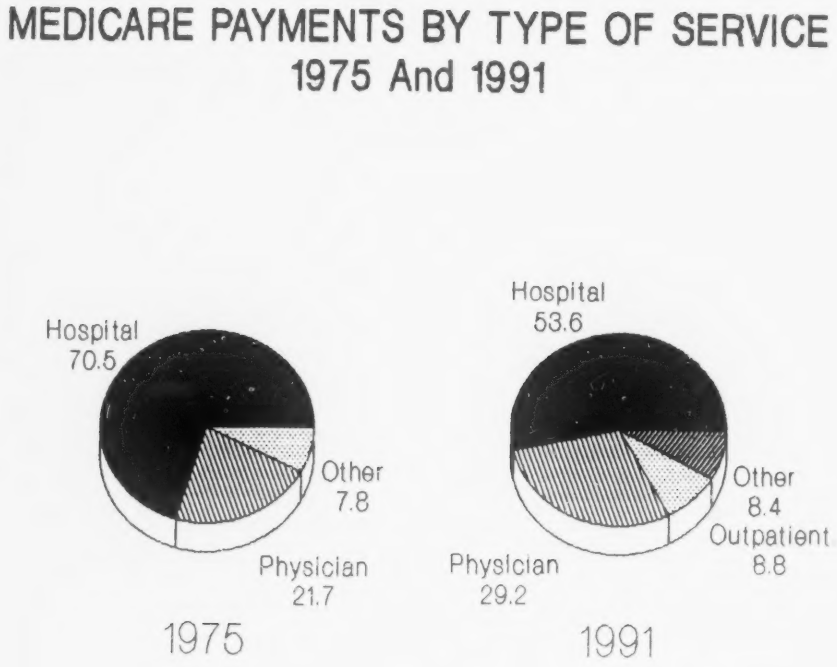
TABLE 6. — MEDICARE BENEFICIARIES SERVED BY TYPE OF SERVICE.

(In Thousands)

Calendar Year	Inpatient Hospital	Skilled Nursing Home	Physician & Medical Services
Aged Persons Served			
1967	3,601	354	6,415
1975	4,913	260	11,396
1980	5,951	248	15,627
1984	6,195	290	18,128
1985	5,714	304	19,590
1986	5,697	294	20,316
1987	5,752	283	21,496
Disabled Persons Served			
1974	397	8	691
1975	472	8	865
1980	721	9	1,631
1984	674	9	1,721
1985	636	10	1,820
1986	645	10	1,888
1987	642	10	1,986

SOURCE: Health Care Financing Administration, 1990.

FIGURE 3 — MEDICARE EXPENDITURES BY TYPE OF SERVICE.



Source: Health Care Financing Adm., 1990

TABLE 7. — MEDICAID BENEFICIARIES SERVED BY TYPE OF SERVICE.

(In Thousands)

Persons Served

Calendar Year	General Hospital	Intermed. Care Facility	Skilled Nursing Facility	Physician Services
1972	2,832		552	12,282
1973	3,256	462	678	13,278
1974	3,291	627	661	14,970
1975	3,432	751	630	15,198
1976	3,551	813	637	15,624
1977	3,768	861	641	16,074
1978	3,782	844	639	15,668
1979	3,608	880	610	15,168
1980	3,680	910	606	13,765
1981	3,703	913	623	14,403
1982	3,530	914	559	13,894
1983	3,696	944	574	14,056
1984	3,467	937	559	14,195
1985	3,434	975	547	14,387
1986	3,544	973	571	14,894
1987	3,767	998	572	15,373
1988	3,832	1,011	579	15,265

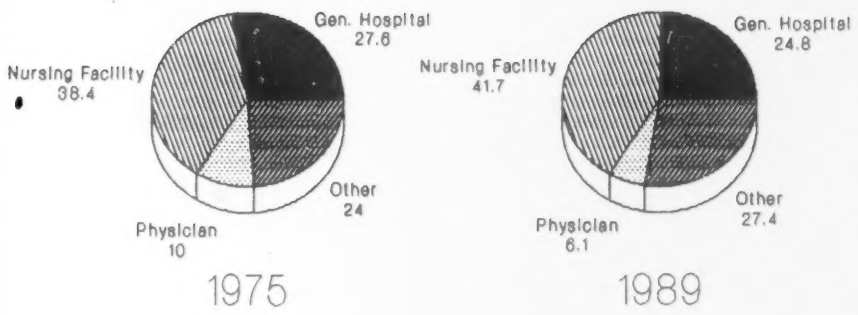
SOURCE: Health Care Financing Administration, 1990.

Looking at the distribution of the $49 billion spent on Medicaid in fiscal year 1988, 29 percent was for nursing home care, 28 percent for hospital inpatient, and 12 percent for Intermediate Care Facilities for the Mentally Retarded (see Figure 4). Thus, the greatest expenses were for nursing homes, even though this was not envisioned when Medicaid was originally passed.

Some selected utilization statistics provide further indication of the impact of Medicare and Medicaid. Figure 5 indicates that the percent of persons who had contact with a physician during a year increased between 1964 and 1988 from 70 percent to 86 percent for the elderly, and from 59 percent to 76 percent for those with family incomes below $10,000 per year. With respect to nursing home care, Figure 6 shows that the number of nursing home residents per population has increased dramatically since 1963. As shown by these statistics, there have been major increases since 1963 in the proportion of elderly and the poor who have received physician and nursing home care, presumably Medicare and Medicaid have played a major role.

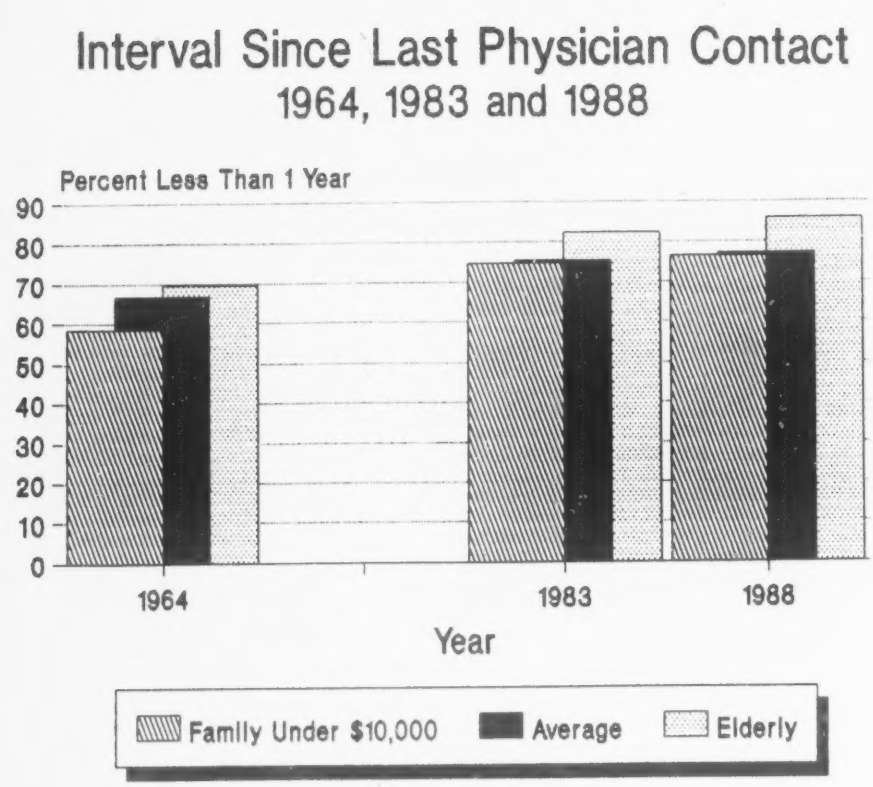
FIGURE 4 — MEDICAID EXPENDITURES BY TYPE OF SERVICE.

MEDICAID PAYMENTS BY TYPE OF SERVICE
1975 And 1989



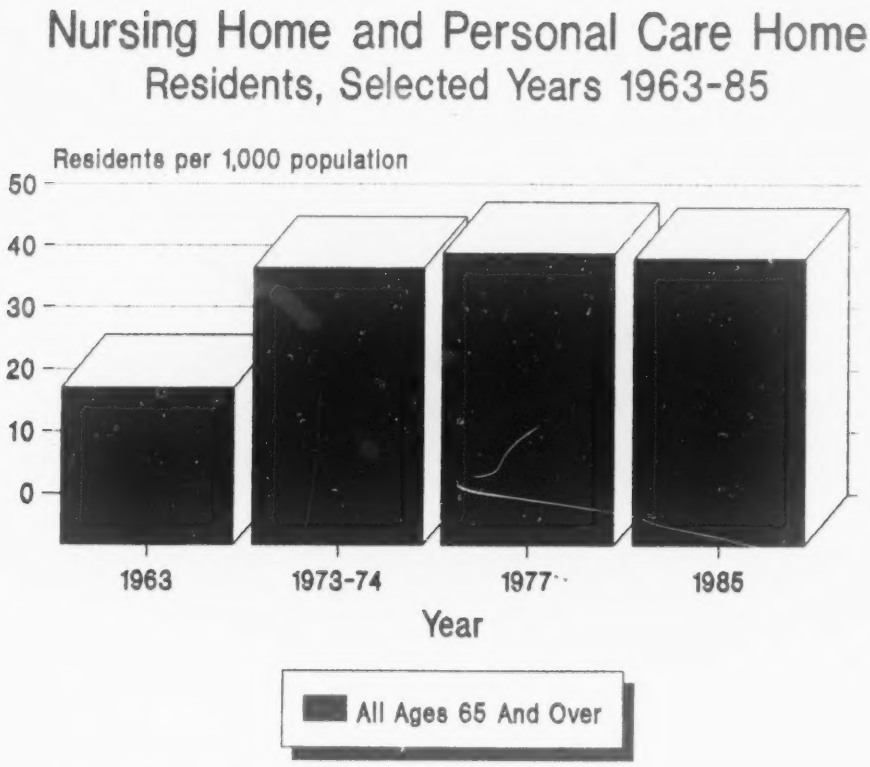
Source: Health Care Financing Adm., 1990

FIGURE 5 — INTERVAL SINCE LAST PHYSICIAN CONTACT.



Source: National Center for Health Statistics, 1990

FIGURE 6 — NURSING HOME RESIDENTS.



Source: National Center for Health Statistics, 1990

UNFINISHED AGENDA — GAPS AND WEAKNESSES IN MEDICARE AND MEDICAID.

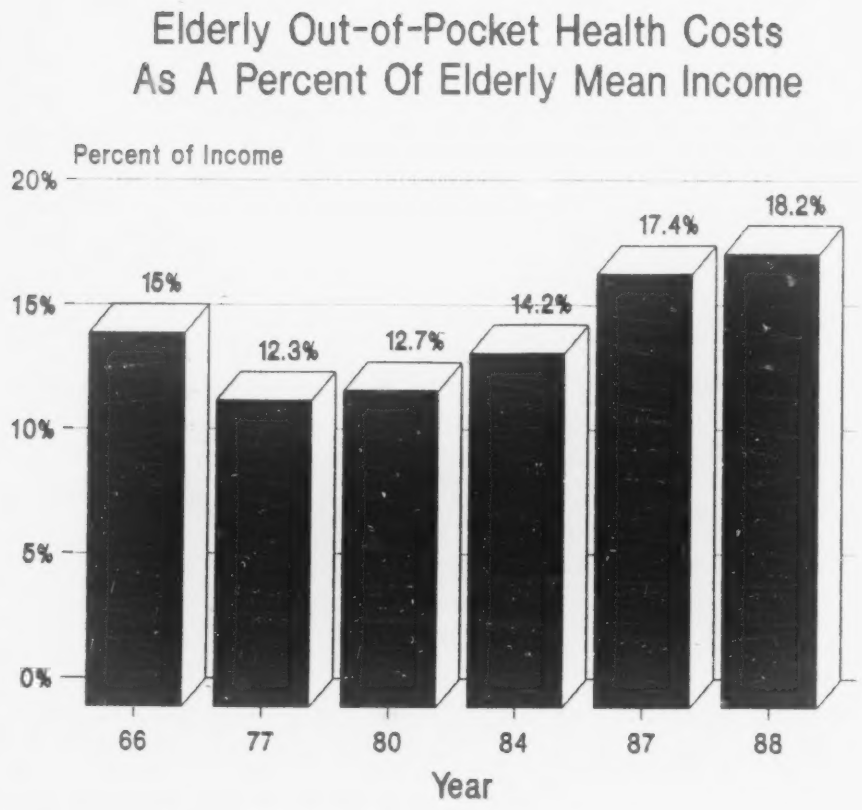
Despite the many accomplishments of these two programs, there still remain many gaps and weaknesses that need to be resolved. This section highlights a few key problems.

Rising health care costs. Health care costs have been rising at rates faster than the cost of living for at least the past two decades. This has created problems for the entire health care field, for employers and employees, for the Medicare and Medicaid programs, and for the elderly, the poor and disabled. For instance, while the Consumer Price Index increased by 23 percent from 1983 to 1989, medical care prices increased by 49 percent during this same time period.

One consequence of medical price inflation is pressure on the Medicare Hospital Trust Fund, now projected to be depleted between 1999 and 2018. The rapid increases for the Medicare and Medicaid programs are motivating policymakers at both the Federal and State levels to search for ways to constrain costs. This could result in the elimination of certain services or the elimination of certain groups from Medicaid. The same scenario is also occurring in the private sector, where employers are cutting back on health benefits.

For the elderly, another consequence of health care cost inflation is that health care costs are consuming an ever greater proportion of their income. Their out-of-pocket costs as a percent of income decreased from 15 percent in 1966 to 12.3 percent in 1977 and then increased to 18.2 percent in 1988 (see Figure 7). Thus, the out-of pocket proportion of income is 20 percent greater than when Medicare was first implemented in 1966 and 50 percent higher than in 1977. If present trends continue, the elderly will soon pay out-of-pocket costs representing more than one-fifth of their incomes.

FIGURE 7 — ELDERLY OUT-OF-POCKET COSTS.



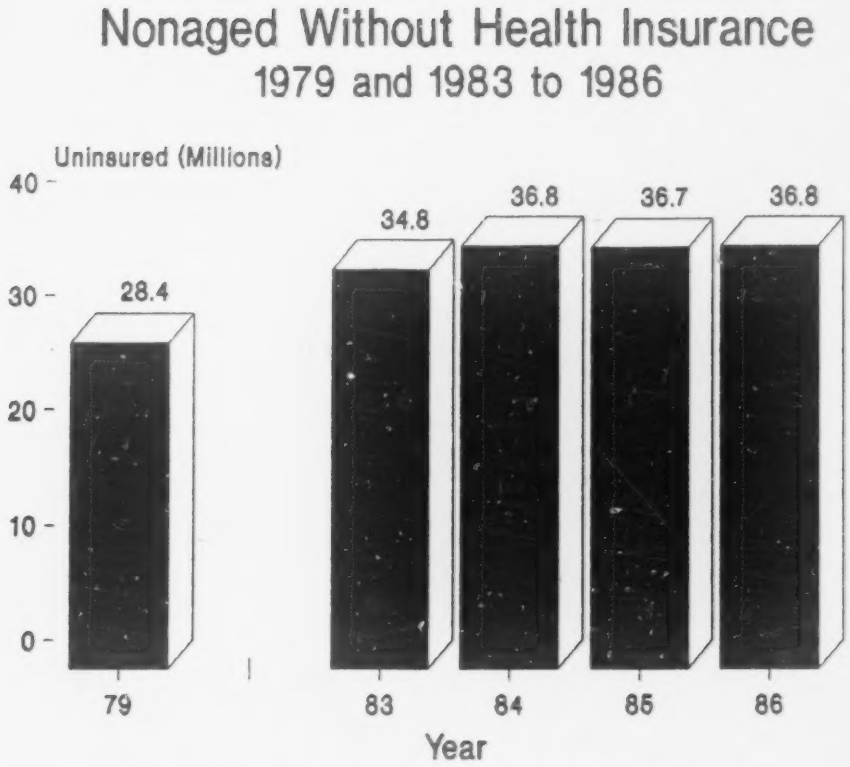
Source: House Committee on Aging, 1990

For the uninsured, the rise in health care costs has major consequences. Many of them are being denied access to even the most critical care. When they do receive such care, they experience staggering bills, which they are unable to pay or which consume a significant portion of their meager incomes. A majority of the uninsured have incomes that are less than 200 percent of the poverty line; yet their out-of-pocket costs of $430 per year are almost equal to those for the insured who on average have substantially higher incomes (US Bipartisan Commission, 1990). The situation is further exacerbated in that the number of uninsured has increased from 28 to 37 million persons between 1979 and 1986 according to the Census Bureau's Current Population Survey (see Figure 8).

Incomplete Quality Assurance. While quality of care has received considerable attention in the last few years, there remain many gaps in monitoring and assurance of high quality medical care. One of the reasons for concern is that there has been reports at Congressional hearings indicating that poor quality care has been delivered. There has also been research showing that, at least for selected surgical procedures, over 30 percent of the cases have been inappropriate (Rand Corporation).

To date there has been no definitive assessment of the quality of care provided by health care providers, largely because of the lack of a sufficiently acceptable set of quality measures. The field is only in the beginning stages in the development of outcome measures, which are the most fundamental in assessing the quality of care, and the initiation of effectiveness research which will test whether or not which medical procedures are more effective than others. Another significant gap is that quality assurance is fragmented between several parties including survey and certification agencies, the peer review organizations, and licensing bodies. There is very little in the way of communications between these entities. Finally, a major limitation is that quality assurance efforts focus on Medicare and, to some extent, on Medicaid, but do very little to protect the privately insured and the uninsured.

FIGURE 8 — UNINSURED.



Source: Current Population Survey, Census Bureau

Recently, several steps have been taken to improve this state of affairs. For instance, the Omnibus Budget Reconciliation Act of 1987 required the implementation of several quality assurance reforms, e.g. a consumer hotline, patient bill of rights, training of home health aides, new survey procedures. These procedures are soon to be implemented. Quality assurance for Health Maintenance Organizations is being beefed up, but is still in the early stages of development. Quality assurance for physician's offices is in the process of early implementation. However, even with these efforts, quality assurance has a long way to go before it fulfills its promise.

Coverage Gaps And Weaknesses. As a result of the repeal of the Medicare Catastrophic Care Act, the Medicare program still has major services uncovered such as extended hospital care, home health care, nursing home care, prescription drugs, and various preventive services. An even greater deficiency is the lack of a really meaningful long term care benefit, outside of Medicaid, for nursing home, home health, adult day care, and other forms of community based care including case management services. These are all critically important services for the elderly and the disabled.

Because States establish many of their own Medicaid policies as to eligibility, the Medicaid program covers only 42 percent of poor persons across all the different states as of 1986. With respect to the many elderly who need nursing home care, they are required to spend all of their assets before they are eligible for Medicaid. Furthermore, even with recent changes, States still vary in the amount of income and assets they will protect for the spouses of those persons needing such care.

As indicated earlier, States have substantial latitude on which services they cover under Medicaid. They may choose to include prescription drugs, eyeglasses, dental care and inpatient psychiatric care. Given this discretion, several states have chosen not to cover these services.

Provider participation. While there are a number of cases where physicians have not accepted Medicare beneficiaries as patients, acceptance of Medicaid patients by hospitals and physicians is a much greater problem. A 1977 study showed that for certain physician groups, i.e. psychiatrists, only 58 percent accepted Medicaid patients. For obstetricians/gynecologists, the number who accepted Medicaid patients was 64 percent. While a 1983 study showed that participation rates for most physician groups did not decline, the participation rate for obstetricians/gynecologists declined to 51 percent.

A recent GAO study on charity care also indicates that a number of hospitals may be providing less than their fair share of care to Medicaid patients. Many hospitals that provide a relatively small amount of charity care also serve a lower percentage of Medicaid patients than the other nonprofit hospitals.

Reimbursement. There have been expressions of concern that Medicare reimbursement levels do not adequately meet actual costs, or at least are less than that paid by private health insurers. However, even more substantial claims of inadequacy are made for the Medicaid program. For example, several studies have shown that Medicaid reimburses physicians at 70-75 percent of Medicare rates. Also, the Virginia Hospital Association, in a recent court suit, contends that Medicaid reimburses its hospitals at 71 percent of their actual costs.

Un- And Underinsured Health Care. Health insurance coverage for 250 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed health care and reduce the personal burden of catastrophic health costs. Every day, personal tragedies are hitting not only millions of individuals with catastrophic illnesses but their families as well. Studies continue to document serious gaps in health insurance coverage. As noted earlier, as many as 37 million persons -- over 14 percent of Americans -- are uninsured.

Of equal concern are the many millions who are underinsured -- those whose existing health insurance coverage is inadequate. Millions of Americans are underinsured when it comes to catastrophic health care costs. For the uninsured and underinsured, the risk is great and growing. One million families have at least one family member who was refused care because of inadequate funds. Up to 10 percent of families face health costs in excess of 10 percent of their incomes.

Un- And Underinsured Long Term Care. When facing a catastrophic long term illness, over 200 million Americans are underinsured, except for the potential protection of Medicaid. A very small percentage of the U.S. population has private long term care insurance. A study by the Brookings Institution shows that the number of people with private long term care insurance will grow, but also clearly shows that a substantial portion of the elderly and many nonelderly are unlikely to ever have private long term care insurance. For all practical purposes, Medicare does not cover long term care. While Medicaid does provide coverage to many persons, it is only after the person needing long term care is impoverished and their spouse has exhausted a substantial portion of his or her income and assets.

A 1987 study by the House Select Committee on Aging showed that over four-fifths of single elderly and over one-half of elderly couples are at risk of spending their incomes down to the poverty level after an elderly person is in a nursing home for six months. While the new Medicaid spousal protection provides some help to the spouse remaining in the community, the nursing home resident is vulnerable to the indignity of having to spend down to poverty. Without long term care protection, the result is that families can face a double catastrophe. The first catastrophe is being hit with the heavy emotional burden of caring for a family member with a long-term disabling illness. The second catastrophe is the huge financial burden and, possibly, the indignity of spending down into poverty or the Medicaid program.

FUTURE OF FEDERAL ROLE IN HEALTH AND LONG TERM CARE

To solve the various gaps and weaknesses in the Medicare and Medicaid programs, two sets of solutions have been proposed. One set is to eliminate as many gaps in these programs as possible. The second is to develop more comprehensive solutions that address the entire health care system and that go beyond just Medicare and Medicaid. This section will highlight several of the key proposals that address many of the above limitations. Time does not permit discussion of all the proposals that deal with each of the above limitations even though all of them need to be addressed. The discussion will first cover changes to Medicare and Medicaid.

Strengthening Medicare And Medicaid. There are many changes to Medicare and Medicaid that have been considered. For Medicare, discussions have included revisiting the provisions of the Catastrophic Care Act that were repealed. As indicated earlier, these could include adding back catastrophic hospital coverage, and the nursing home, home health, and prescription drug benefits.

Additional proposals primarily address the need for a comprehensive long term care benefit for the frail elderly and other persons with disabilities. Estimates are that by the year 2030 about 4 million persons will reside in nursing homes and 12 million disabled elderly will live in the community with needs for daily assistance. For these persons, long term care benefits are needed that include more extensive nursing home, home heath, and other community based care services. All of these services could just be added to the Medicare program or they could be added to the Medicaid program.

The long-term care expansions of Medicaid could take the form of either additions in services to the basic program or in the form of a long term care block grant program that involves combining funds from several different Federal programs into one pool to be administered by the States. One way of making additions to Medicaid is to change the Home and Community Based Waiver Program so that waivers are no longer required and that States could simply add this benefit at their option for the frail elderly. Another proposed change is to increase the housing allowance, or further increase the income and assets protected for either an institutionalized individual and/or their spouse.

Other changes that have been proposed for Medicaid include establishing uniform eligibility standards across all states that ensure that all persons below the poverty line are covered and possibly go to higher thresholds such as 185 percent of the poverty line for high priority groups. Another approach is that Congress could require all states to cover the medically needy. Other approaches address some of the weaknesses discussed above, including increases in reimbursement levels to providers. Finally, proposals have been offered to provide ways for the uninsured and underinsured to be covered through Medicaid. Various methods could be used to include these groups, such as payment from State or Federal revenue sources, by employers, or by the individuals.

Comprehensive Health and Long Term Care Reform. As was the case in the late 1970s, a number of proposals for comprehensive health care reform have emerged. This section will review several major proposals that represent a range of different approaches, including proposals offered by coalition groups.

One proposal, recently made by the US Bipartisan Commission (otherwise known as the Pepper Commission) represents an approach of requiring employers to ensure coverage for their employees and of extending Medicare and a revised version of Medicaid. Their recommendations included the following:

Universal Health Care Coverage:

- Businesses with more than 100 employees would provide private health insurance or contribute to a public plan for all employees and non-working dependents.
- Businesses with 100 or fewer employees would be encouraged to provide health insurance for employees and non-working dependents. Tax credits for some small employers would be available.
- The federally operated public plan would cover employees and dependents that contribute and non-working individuals who buy in or are subsidized. The plan would replace Medicaid for the specified services and would pay providers according to Medicare rules.
- The minimum benefit package would include primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

Long-Term Care:

- The Commission plan would establish a Nursing Home Program that would provide financial protection and ensure that no one faces impoverishment.
- Nursing home patients would be entitled to social insurance for the first three months of nursing home care. Such front end insurance would allow people who have short stays to return home with resources intact.
- Severely disabled persons would be eligible for social insurance for home and community-based care.
- The Federal government would finance the home and community-based care program and the front end nursing home care. The Federal and State governments would share in financing the Nursing Home Program.
- Private long-term care insurance, subject to government oversight, would fill gaps not covered by the plan.

There are several other comprehensive proposals that have been discussed and take somewhat similar approaches to the Pepper Commission. The Basic Health Benefits for All Americans Act proposes a pluralistic health care system with a public-private partnership to assure care. Employers are required to cover their employees and Medicaid programs are expanded to cover the poor and near poor. The Act requires all working Americans and their dependents, as well as the uninsured to have basic health insurance. For Americans who are not covered by Medicare and unable to participate in employment based insurance, the legislation establishes a phased-in public Federal/State program to provide subsidized insurance coverage. The required benefits package must include most acute care, some preventive care and catastrophic coverage limiting out-of-pocket costs for covered services to $3,000 per family. This proposal does not include a long-term care benefit package.

Another acute care oriented proposal is The National Leadership Commission on Health Care Proposal. The proposal retains the Medicare program and private insurance. The Federal government would provide guidelines for a new Universal Access program which would not be centrally directed as is the Medicare program. The proposal requires all Americans to have basic health insurance, whether obtained privately, publicly or by employer benefit plans. Older Americans would continue to receive Medicare coverage. The National Leadership Commission does not consider it appropriate for it to establish the original national basic benefits package for all Americans. However, the Commission recommends that mental health benefits and preventive services, especially prenatal care, be included in this package. As with the previous plan, the Commission did not specifically address long-term care.

Another variation is The Health Security Partnership Plan which retains the Medicare program with the remaining people being covered by a State system based within Federal guidelines. Private insurance would be continued in modified form, and may serve as qualified insurance delivery plans to be selected by employees and those not with an employer through which they may receive benefits. Medicare continues with its payment practices and standards integrated in the Health Security Partnership over time. The plan provides universal coverage for all U.S. residents. The Medicaid program would be folded into the public program. The basic benefits package to which all eligible individuals are entitled is comprehensive in nature. A beginning long-term care program which provides added benefits for those past the age of 65 and the disabled is to be inaugurated in the first phase. In the second and third phases, eligibility is to be extended to those under the age of one, and then to the rest of the population.

Though not a separate proposal, the Canadian National Medicare Model has been given much consideration. Canada's plan is administered by ten Provincial governments which operate within the Canadian Federal government's guidelines. It provides universal access to all legal residents of a province after a short waiting period. Comprehensive coverage includes all medically required services rendered by medical practitioners in hospitals, clinics or doctor's offices. Inpatient and outpatient hospital care, prescription drugs, diagnostic and lab tests, mental health care as well as preventive care including pre-natal and well-baby care are also covered. Limited dental care is available in some provinces. In contrast to Canada's well-established acute health care system, the financing and delivery of long-term care are in a state of change, with some coverage, but significant variation among the provinces.

Finally, a federally-oriented approach has been offered by Congressman Roybal, Chairman of the House Aging Committee, under the title of the USHealth Program Act (H.R. 2980). It establishes a Federal program based on Medicare and managed by the USHealth Administration, the current Health Care Financing Administration. USHealth replaces Medicare, Medicaid and private insurance plans and is set up as an independent agency and. Most bill processing and review is to be provided through contracts with private insurance companies. Within the USHealth Program Act, financial access is ensured by making every citizen and permanent resident eligible. The basic health and long term care benefits include those covered by Medicare, dental services, prescription drugs, preventive services and long term care (care management services, home and community-based care, nursing home care). Total expenditures under USHealth are capped at 12 percent of the Gross National Product.

CONCLUSION.

Though the rich history of Medicare and Medicaid is replete with lessons for the future, the question remains as to whether or not this nation will take the time and has the wisdom to learn those lessons. Twenty-five years ago on July 30, 1985, a President and a Congress took the bold and courageous action to enact a protection package for millions of elderly, poor and disabled. No one then thought Medicare and Medicaid were the perfect solutions, but few doubted that many people's lives would be much better as a result of that bold action. Today, few dispute that millions of Americans are better off due to Medicare and Medicaid.

Looking to the future, the nation has two responsibilities. The first responsibility is one of stewardship over Medicare and Medicaid as they are today. Just maintaining the health and well-being of these two programs will be no minor task for the Administration and Congress. It is a task that will be made more difficult to the extent that it is done in an adversarial environment. Most Americans agree that Medicare and Medicaid are too important to be allowed to fall victim to partisanship and expect their national leaders to fulfill their stewardship responsibilities.

The second responsibility is to those who have yet to benefit from this nation's greatest step forward toward protecting the health of its citizens. When millions live at risk and in fear of a long term disabling illness wiping out the financial and emotional resources of their families, a nation cannot be satisfied with Medicaid as the nation's long term care policy. When millions are forced to seek charity for whatever health care they need, a nation can feel no pride in having the best medical care in the world.

In a world which has increasing doubts over the United States' ability to step forward and show leadership on the great issues of the day, health and long term care protection is one case where this nation not only fails to lead but fails to keep up. Twenty-five years would seem to have been more than enough time for this nation to take its rightful place of leadership; thirty years is too long.